

PRINTED: 02/18/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2011
NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 450 COLLEGE ST NEWPORT, TN 37821		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies An annual Licensure survey was completed on February 16, 2011, at Baptist Convalescent Center. No deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

5599

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If continuation sheet 1 of 1